SOUTH DAKOTA DEPARTMENT OF HEALTH WIC PROGRAM
REQUEST FOR APPROVAL OF SPECIAL FORMULA AND
MEDICAL NUTRITIONAL PRODUCTS

Date of Request:_____Participant Name: _____

Date of Birth:_____Parent/Guardian:_____

Diagnosis (Indicate with an "x" the medical diagnosis):
Only medical diagnosis with ICD-9 codes will be accepted

_____Asthma	_____Malabsorption Syndromes	_____Reflux
_____Carbohydrate intolerance	_____Metabolic disorders	_____Renal Disease
_____Failure to Thrive	_____Organic heart disease	
_____GI Disorders	_____Prematurity	
_____Inborn Errors of Metabolism	_____Protein Allergies (e.g. cow's milk or soy protein)	

Other: Please enter diagnosis description rather than ICD-9code:_____
"Formula Intolerance" and Intolerance Symptoms will not be accepted.

REBATE RECEIVED FOR: ENFAMIL AR LIPIL, ENFAMIL LACTO-FREE LIPIL, ENFAMIL GENTLEASE LIPIL

Special Formula/Medical Nutritional Product:_____
NAME AND BRAND

Flavor:_____Prescribed Amount:_____

Form of Formula: _____Powder _____Concentrate _____RTF

Estimated Length of Time to Be On This Formula/Medical Nutritional Product: (Check one)

☐ One Month; ☐ Three Months; ☐ Six Months; ☐ One Year; ☐ Other_____

Comments:_____
_____
_____

Print Name:_____Telephone:_____
PRESCRIPTIVE HEALTH AUTHORITY'S NAME

Signature:_____Date:_____
PRESCRIPTIVE HEALTH AUTHORITY'S NAME

SUBMIT FORM TO LOCAL WIC OFFICE FOR APPROVAL

For WIC Office Use Only: New _____ Renewal_____ Currently Breastfeeding _____

Payee Name_____

Family ID#_____ Client ID# _____Local Agency/Clinic Code_____

Amount to be Issued to Participant Monthly_____ Number of Months Special Formula Approved_____

Specific months:
JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

Approval Signature _____ Date_____
WIC HEALTH PROFESSIONAL

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